UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

BYETTA (exenatide)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA

Patient is:

- age 17 and above
- **Not using insulin**
- using Byetta as adjunct therapy in patient with Type II diabetes
- not using Byetta as a substitute for insulin
- taking Metformin, a sulfoneura **(identify by name**) or both

OR

a TZD ('glitazone' - identify by name) alone or in combination with metformin

- not in end-stage renal disease
- not on dialysis
- not diagnosed with gastroparesis
- information showing lack of glycemic control

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Written request from physician showing patient is stable on Byetta and patient is not on insulin